ATTENDING PHYSICIAN'S STATEMENT

Type or Print all information

Employee Name: _____

Physician's Name: _____

Address: _____

Telephone No.: _____

E-mail Address: _____

Diagnosis:

_____

_____

_____

_____

Prognosis:

_____

_____

_____

_____

Is the patient's condition expected to substantially impair the patient's ability to perform material and substantial duties of his or her job for a period of ***not less than six weeks***? _____Yes _____No

When do you estimate the employee can return to work? Date: _____

I hereby certify that I am a physician licensed to practice medicine in the State of Texas or another domestic state, and that the foregoing statements are true and

_____ _____

Physician's Signature Date

SICK LEAVE POOL WITHDRAWAL REQUEST FORM

Type or Print all information

Employee Name: _____

Date of Birth: _____

Mailing Address: _____

Employee Home/Cell Number: _____

E-mail Address: _____

Social Security Number(last 4): XXX-XX-_____

Department Name : _____

Job Title: _____

Hire Date: _____

During the previous fiscal year, I donated _____ hours to the SLP program.

During the present fiscal year, I donated _____hours to the SLP program.

I certify that I **have** used all available sick leave, annual leave, personal holiday leave, and compensatory time as of this date: _____ ,20____

Date on which Catastrophic illness or injury commenced _____, 20____

Number of hours of leave requested from the Sick Leave Pool : _____ Hours.

Reason for requesting hours from the Sick Leave Pool Program:

_____

_____

_____

I hereby certify that the sick leave hours I am requesting are necessary and that my condition meets the definition of "catastrophic illness or injury" set forth in the Sick Leave Pool Program manual.

Furthermore, I understand that the completed SLP Withdrawl Request Form, along with all of the required documentation and information must be submitted no more than ten (10) days prior to the exhaustion of all of the employee's accrued sick leave, annual leave, personal holidays, and compensatory time to avoid a gap in compensation because retroactive benefits will not be granted in any case.

The obligation to submit said forms and required documentation and information shall be the employee's responsability. The employee's failure to complete said form and provide the required documentation and information may result in the denial or delay of any grant of time from the SLP. If an employee is critically ill and unable to file the SLP Withdrawal Request Form and required documentation and information, the employee's immediate familly may, submit the request form and requirred documentation and information.

Employee Signature

Date